National Partnership for Women & Families

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Good afternoon, Chairman Deal, Ranking Member Brown, and other members of the Committee. My name is Jane Loewenson, and I am the Director of Health Policy for the National Partnership for Women & Families. Thank you for the opportunity to testify before you today on patient safety and health care quality. I appreciate the opportunity to share the National Partnership's views.

The National Partnership for Women & Families is a non-profit, nonpartisan advocacy organization that has long fought for economic, employment and health security for all women and families. The Partnership has more than 30 years of experience promoting fairness in the workplace, policies that help women and men meet the competing demands of work and family, and access to quality health care.

Over the past six years, the news about the quality of our health care system has been grim. The Institute of Medicine's (IOM) reports, *To Err is Human* and *Crossing the Quality Chasm*, document the wide gap between the health care that Americans are

getting and what health care could and should be. In fact, more people die in hospitals from preventable medical errors than from breast cancer and AIDS combined. The IOM reports also document pervasive misuse, under-use and overuse of treatments and diagnostic tests. A recent study by the RAND Corporation found that an American's likelihood of getting the right care at the right time was about 50/50, no better than the toss of a coin. The evidence is clear: medical errors and poor quality take an enormous toll on our health and our lives.

The National Partnership is committed to improving the quality of our health care system, because health care is central to the vitality and economic security of women and their families. The responsibility to make health care decisions for their families often falls to women. Yet there is very little meaningful information to help with such important decisions as choosing a doctor or hospital. No tool exists that provides a complete picture of the quality and safety of the care delivered by providers. Consumers are left to hope that they receive optimal care in a health care system that fails patients far too often.

At the National Partnership for Women & Families, we believe that a critical strategy for reducing medical errors and improving the quality of our health care system is to enable Americans to select hospitals, physicians, and other providers on the basis of publicly reported, standardized performance information.

My testimony today touches briefly on the patient safety legislation that was under consideration during the last Congress. However, it will primarily focus on the critical need for greater transparency in our health care system.

Patient Safety Legislation in the 108th Congress

In response to the finding that as many as 98,000 people die of preventable medical errors in hospitals, the Institute of Medicine called for a both a national mandatory reporting system for serious medical errors, and a voluntary system for more minor errors or near misses. The National Partnership strongly supports those recommendations.

While creating a mandatory reporting system for medical errors is a key goal for the National Partnership, we also strongly supported passage of patient safety legislation during the last Congress that would create patient safety organizations to collect and analyze voluntary, confidential reports of medical mistakes. Creating such a mechanism would be an important step forward, although only part of the equation. To make a voluntary system as effective as possible and to avoid undermining other efforts to improve health care quality, we believe that patient safety legislation should address several key issues.

The legislation should provide a clear definition of patient safety information. A certain level of confidentiality and protection from legal discovery is needed to encourage the voluntary reporting of medical errors and near misses. This protection, however, should not shield information from a patient that they otherwise would have access to, nor should it preclude information, where appropriate, from use in criminal proceedings. Legislation should also protect federal, state, and local reporting requirements, such as those for public health.

Public reporting is a powerful incentive for quality improvement, and patient safety legislation should not undermine it. The confidential reporting of information to

patient safety organizations should not hide from public view information that otherwise would be subject to public reporting. It should preserve the reporting of performance information that increasingly has been required by purchasers, states and accrediting organizations.

An effective voluntary reporting system also depends on having qualified independent organizations to collect and analyze the data reported by providers. We believe the legislation should include a rigorous certification process for patient safety organizations, evaluation of the qualifications and operations of these organizations including the ability to maintain the privacy of patient records, and clear requirements for what they should do with the data they collect. The process for certifying patient safety organizations should protect against conflicts of interest.

The National Partnership appreciates all the work this committee has done on patient safety legislation and hopes that a bill moves forward during this session of the Congress.

Performance Measurement and Public Reporting

Now let me turn to the primary focus of my testimony today: the critical need for the public reporting of comparative information on how well physicians, hospitals, and other providers are delivering care. We support the IOM definition of quality as care that is safe, timely, effective, efficient, equitable, and patient-centered, and agree that these elements should be measured.

Right now, it is easier to get information about the performance of a company's stock than the performance of a doctor. And consumers have more information about the

safety record of a car than the safety record of a hospital. It is our view that this reality must change. People should have access to objective, comparable information that allows them to choose the best surgeon for their bypass surgery, the safest hospital for giving birth, the physician who will do the best job of keeping their diabetes under control, or the pediatrician who will best treat their child's asthma so that they can avoid trips to the emergency room.

At the National Partnership, we believe it is not only possible, but imperative, to evaluate and publicly report providers' performance on standardized quality measures. This will enable people to have meaningful information to guide their health care decisions. Not only do we believe people have a right to this information, there is strong evidence that measurement drives quality improvement and that quality improves even more dramatically when information is publicly reported.

There are multiple efforts to measure and report quality and safety information in both the private and public sector. I will describe three concrete examples:

1. New York

One of the oldest public reporting efforts is in New York State. Since 1989, the New York State Department of Health has published annual data on risk-adjusted mortality following coronary artery bypass graft (CABG) for each hospital and surgeon. Between 1989 and 1992, mortality from bypass surgery fell 41 percent statewide in New York. By 1992, New York had the lowest risk-adjusted mortality rate of any state in the nation for bypass surgery and the most rapid rate of decline in any state with below-average

mortality. This example clearly demonstrates the relationship between public reporting and better health outcomes.

2. Wisconsin

A second example of the impact of public reporting and performance measurement is Wisconsin's *QualityCounts* Report. This report, released in the fall of 2001, reported 24 hospitals' performance across five categories: surgery, non-surgery, hip/knee surgery, cardiac care, and maternity care. *QualityCounts* was the first public report on hospital quality issued in this region and it generated substantial interest. Of the 24 hospitals, eight performed poorly in obstetrics and three had poor scores in cardiac care.

An evaluation of the *QualityCounts* experience, published in *Health Affairs* in 2003, found that public reporting of performance led to greater quality improvement activities. The evaluation compared the hospitals that had their performance publicly reported with those that received a private report of their performance and those that received no report. The study found clearly demonstrates that hospitals that publicly reporting their performance undertook the greatest number of quality improvement activities.

3. Minnesota

Minnesota's Adverse Health Event Reporting Law was passed during the 2003 legislative session, and mandated hospitals to report the occurrence of any of the 27 "never events" endorsed by the National Quality Forum (NQF). The purpose of the law

is to learn from serious medical errors, so that harm to patients can be prevented. Examples of "never events" include:

- Retention of a foreign object in a patient after surgery;
- Wrong-site surgery; and
- Acquisition of a very serious pressure ulcer (or bed sore) after admission.

Minnesota is the first state to fully implement the "never event" reporting. Hospitals are required to report information on the event, along with their determination of why the event happened and what they are doing to prevent the event from happening again. This past January, the Minnesota Department of Health reported that, over the course of 15 months, there were 99 incidences of "never events" and named the hospitals in which they occurred. Findings from the report include:

- 31 patients had foreign objects left in them after surgery;
- 24 patients acquired a serious pressure ulcer (or bed sore) after admission;
- 13 patients had surgery on the wrong part of their body.

Some examples of corrective action plans that hospitals have submitted include: 1) purchasing surgical sponges and other materials that are easier to track and count; 2) marking the surgical site prior to surgery; and 3) setting up physicians orders to make sure patients at risk for bed sores are re-positioned on a regular basis. The fact that health care providers in Minnesota's hospitals are reporting serious errors and identifying ways to prevent harm to patients is a major step forward in patient safety.

From the examples I have described, as well as others, we have learned that:

- Quality can be measured;
- What gets measured gets improved; and
- What gets measured and publicly reported gets improved even more.

The National Partnership recognizes that measurement and public reporting are powerful mechanisms to address the safety and quality crisis in the health care system. We have embraced a vision of a transparent health care market, one in which standardized, comparative information on provider performance is available to the public. To advance this vision, the National Partnership has forged a groundbreaking collaborative – the Consumer-Purchaser Disclosure Project. The National Partnership co-leads and provides the organizational home for this effort. The Disclosure Project is a coalition of large employers, business coalitions, and consumer organizations and labor unions that have united around a common goal of making our health care system more transparent by:

1. Championing performance measures that reflect consumer and purchaser needs through the National Quality Forum's (NQF) consensus-based endorsement process;
2. Encouraging the implementation and public reporting of NQF-endorsed measures by public and private purchasers, accreditation bodies, health plans, and other key stakeholders; and
3. Encouraging the development of new standardized quality measures such as infection or complication rates, or patient experience with providers, so that

consumers and purchasers have a more complete and meaningful picture of the quality of care**.**

Through our work on the Disclosure Project, we recognized the need for additional consumer engagement around the issues of patient safety and quality improvement. Consumers are the ultimate stakeholder in health care, yet their voices can be lost among the multitude of other interests in a complex health care system. In response, the National Partnership recently launched a major initiative, with support from the Robert Wood Johnson Foundation, to engage consumer advocates at the local, state, and national level in these issues.

Going forward, the National Partnership welcomes the opportunity to provide you with further information on our activities and perspective as you consider the issues of patient safety and quality improvement. We appreciate the Subcommittee's interest in these issues and thank you for the opportunity to testify this afternoon.